

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial permit. Then please remove of bolt from page 2 and seal it with 24 hour after death with the State Dept. of Health and Mental Hygiene prior to burial. Cremation should be done within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other trauma

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												26207											
											REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Rose						Elizabeth			Chasson			09-17-87						10:40am					
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female			White			10 01 1923						63 YRS.			MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH											
Maryland			U. S. A.			Calvert						Calvert			MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Prince Frederick			Calvert Memorial Hospital			Home Maker.			13. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE											
13a. STATE COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			P.O. BOX 82 20733											
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
GEORGE			CHASSON			ALICE			WILLIAMS			No			N/A			219-12-2833 Shirley A. Matula, Seaford, Va. 23696			104 Pamela Place		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of lung (left)</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>status Epilepticus, Bilateral Pneumonia</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/17/87											
22b. SIGNATURE <u>Mathur</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Prince Frederick, MD 20678																	
M. Mathur																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
BURIAL			09-19-87			TRINITY MEM. GRDNS.			WALDORF			CHARLES			MD.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
AREHART FUNERAL HOME, INC., LA PLATA, MD.						SEP 21 1987																	

1855 32 8883230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death.

(HARDBACK): If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at 410-752-5571.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					2627				
REG. NO.					26. HOUR				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Mary	G.	Decatur		September	27, 1987			0937 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	Cacasician	Feb. 10, 1902			85 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Calvert	
Tennessee	U.S.A.							MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Prince Frederick	Calvert Memorial Hospital					Homemaker			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland	Calvert	Dunkirk				11626 Rivershore Drive			20754
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Homer		Gray	Reno					Birchfield	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No	577-14-7527	Herbert Byrd	same as 13e			5-10 min			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension, suspected pulmonary embolism</u> several hrs									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Upper Gastrointestinal Bleeding</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>87</u> , to <u>9-27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> , 19 <u>87</u> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Schlager, M.D.</u>	DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9-27-87</u>		
22d. PHYSICIAN'S NAME (IN BLOCK LETTERS)	22e. ADDRESS								
Robert Schlager, M.D.					Prince Frederick, Maryland 20678				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL Georgetown University Medical School			23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE		
Removal	9-27-87				Washington, D.C.				
24. FUNERAL DIRECTOR NAME	24b. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE			
Columbia Mortuary Services Inc. 9013 Annapolis Rd. Lanham, MD, 20706						10107 1987			
DHMH - 16 60M 7/84 (VRA 15, 4)									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be forwarded to the funeral director for use as the burial permit. Then please remove carbon paper. Page 4 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be forwarded to the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26271

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Julius Francis Johnson				Sept. 15, 1987			0958a m		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		Black		Sept. 12 1907		80		MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. DATE OF BIRTH		9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 24 HRS	
Maryland		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Calvert county,		MONTHS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
Prince Frederick		Calvert Memorial Hospital		Farmer					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland	Calvert	Lusby	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 18 Sollers Wharf Rd. 20657				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
Somerset			Johnson	Lucinda			Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
no		217-01-1381		Flossie Johnson		Box 18 Sollers Wharf Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of Prostate 2 yrs									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CVA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
—		—				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 9/9/87, to 9/9/87, that (I) (we) last saw the deceased alive on 9/9/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
Atul Shah		Prince Frederick		MD 20678					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY	
Burial		Sept. 19-87		St. Johns Chr. Cem.		Lusby		Calvert	
24. FUNERAL DIRECTOR NAME		1451 Dares Beach Rd.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Spencer E. Sewell		Prince Frederick, Md		SEP 18 1987		Julia Landon Radke			

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20TH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use on the burial permit. This certificate is carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 26272
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM F KASTNER JR</b>			2a. DATE OF DEATH <b>September 26th 1987</b>	2b. HOUR <b>2247p.m.</b>
3. SEX <b>male</b>		4. RACE <b>white</b>	5. DATE OF BIRTH <b>Aug. 27th 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Calvert County</b>
10. CITY OR TOWN OF DEATH <b>Prince Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Calvert Memorial Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Production Div.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Calvert</b>	13c. CITY OR TOWN <b>Pr. Frederick</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>William F. Kastner, Sr.</b>		MIDDLE  LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy Hoffman</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>	17. INFORMANT  <b>Ruth Kastner, Same as #13 A-E</b>	ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  <b>CARCINOMA PROSTATE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY <b>Calvert</b> STATE <b>Md.</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>87</b> , to <b>9/26</b> , 19 <b>87</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>9/26</b> , 19 <b>87</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (we) did <b>(not)</b> view the body after death.				
22b. SIGNATURE  <i>John Judge</i>		DEGREE	22c. DATE SIGNED <b>9/27/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
		22e. ADDRESS <b>Prince Frederick, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-1-1987</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Christ Episcopal Ch.</b>	23d. LOCATION CITY OR TOWN <b>Port Republic</b> , COUNTY <b>Calvert</b> , STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Donald V. Borgwardt</b>	ADDRESS  <b>Rt 264, Box 34B, Port Republic, Maryland 20676</b>	25a. DATE REC'D. BY REGISTRAR <b>OCT 05 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John Judge</i>

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8 / 2627

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR			
DECEASED NAME (TYPE OR PRINT)	Ronald	Lee	Lanier	Sept 29	1987						
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR				
Male	White	MONTH	DAY	YEAR	52	YRS	MONTHS	DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
West VA.	USA				Calvert			MONTHS	HOURS		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Dunkirk <i>diabetic</i>	1453 Knight Ave					Communications			US Gov't		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
MD	Calvert	Dunkirk	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	1453 Knight Ave/20754			LAST			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			17. INFORMANT	ADDRESS
Cecil			Lanier	Elsie			yes			Joyce A. Lanier	(same)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Arrhythmia</u>											5-10 min.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic/Ischemic Myocardopathy</u>											5-10 min.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Diabetes / Liver Cirrhosis.</u>											Years.
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <u>Sept 29</u> 19 <u>87</u> to <u>Sept 29</u> 19 <u>87</u> that <input checked="" type="checkbox"/> (we) <input type="checkbox"/> lost saw the deceased alive on <u>Sept 29</u> 19 <u>87</u> and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <u>Gerald P. Stern</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>Sept 29, 1987</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gerald P. Stern MD</u>	22e. ADDRESS <u>Owings, Md. 20736</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-2-87	23c. NAME OF CEMETERY OR CREMATORIAL MD Veterans	23d. LOCATION Cheltenham	23e. COUNTY PG	23f. STATE MD						
24. FUNERAL DIRECTOR NAME Rausch FH	25a. DATE REC'D. BY REGISTRAR OCT 05 1987	25b. REGISTRAR'S SIGNATURE <u>John P. Rausch</u>									
DHMH - 16 60M 7/B4 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of the certificate and mail it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
John William LEITCH Jr.						09/02/87				15.13
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White	MONTH 12 DAY 10 YEAR 06			80	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD				
10. CITY OR TOWN OF DEATH Pr. Frederick, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Tobacco		
13a. STATE MD	13b. COUNTY Calvert	13c. CITY OR TOWN Huntingtown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4170 Hunting Creek Rd/20639					
14. FATHER'S NAME FIRST John		MIDDLE William	LAST Leitch Sr	15. MOTHER'S M AIDEN NAME Emily		G.	LAST Colton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no n/a		17. INFORMANT		ADDRESS 4977 Battery Lane Apt 604 Jane W. Leitch Bethesda, MD 20814				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Organic Brain Syndrome, Emphysema, Advance Age</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>04/21/84</u> to <u>09/02/87</u> , 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death.										
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9-2-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Ronald J. Ross, MD		Prince Frederick, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL A11 Saints Episcopal			23d. LOCATION CITY OR TOWN Sunderland		COUNTY Calvert	STATE MD	
24. FUNERAL DIRECTOR NAME Rausch FH		ADDRESS Owings, MD 20736	25a. DATE RECEIVED BY REGISTRAR 1 SEP 8 1987			25b. REGISTRAR'S SIGNATURE <u>Julia D. Darden, R.N.</u>				

100-932 510280



100-932 510280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is a carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any entry, an other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26275	
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20 DATE OF DEATH MONTH DAY YEAR		20 HOUR		REG. NO.	
Sonia Kruger Manuel						09 29 87		2304		26275	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
Female		White		03 29 16		71					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
GA		USA						Calvert		Calvert	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Pr. Frederick		Calvert Memorial Hospital						Clerk		US Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	MD	13b. COUNTY	Calvert	13c. CITY OR TOWN	North Beach	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		142 Island View Dr.	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		unk	
Robert				Harmon		Elizabeth					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		n/a		254 12 2777		Harriett Williamson		142 Island View Dr. Annapolis, MD 21401			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>											
DO TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Edema</u>											
DO TO, OR AS A CONSEQUENCE OF (c) <u>Pancreatic Carcinoma</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from <u>September 9, 1987</u> to <u>September 9, 1987</u> , that (1) we last saw the deceased alive on <u>September 9, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death.											
22b. SIGNATURE <u>Wayne Zuroski M.D.</u>		DEGREE <u>M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/30/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Wayne Zuroski M.D.		Pr. Frederick, Md. 20678									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE			
cremation		10-02-87		Cedar Hill		Suitland		PG MD			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Rausch FH		Owings, MD 20736						OCT 05 1987			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove part 1 and page 4 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 / 26278  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
T. DECEASED NAME (TYPE OR PRINT)			LAST			9	15	87	1110 a.m.
Victor Emil Martin									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		MONTH 6 DAY 27 YEAR 1907		80		IF UNDER 21 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		U.S.A.				Calvert			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Prince Frederick		Calvert Memorial		13a. STATE Maryland 13b. COUNTY Calvert 13c. CITY OR TOWN Solomons		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 31 20688	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Emil		Emil Martin		Lena		NO		054-03-3525	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		17. INFORMANT ADDRESS							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DOROTHY M. MARTIN same as #13							
Sleptotic coma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC LIVER DISEASE							
		DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF PANCREAS 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/20/1987 to 9/11/1987, that (I) (we) last saw the deceased alive on 9/11/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anwar Munshi		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.		22e. ADDRESS Prince Frederick, Md. 20678							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-16-1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria Fairfax		COUNTY STATE Va	
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt Box 34-B Port Republic, Md. 20676		25a. SIGNED AND FILED BY REG. NO. 25b. REGISTERED SIGNATURE SEP 21 1987							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copy. Page 1 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury or other traumatic event, the medical examiner should be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 / 26277				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Georgia Vera Meredith										September	20	1987		2217 M
3. SEX female	4. RACE white			5. DATE OF BIRTH MONTH 09 DAY 29 YEAR 17			6. AGE (IN YEARS LAST BIRTHDAY) 69			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.				
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/clerk.			12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning							
13a. STATE MD	13b. COUNTY Calvert	13c. CITY OR TOWN Dunkirk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 139 Hallmark Dr./20754								
14. FATHER'S NAME FIRST William	MIDDLE B.	LAST Hensley	15. MOTHER'S MAIDEN NAME FIRST Callie			MIDDLE	LAST Rogers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. n/a			17. INFORMANT Patricia Styles (same)			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPTIC SHOCK</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>PROGRESSIVE SUPRAVENTRAL PALSY</u>														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 20</u> , 19 <u>87</u> , to <u>SEPT 20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>SEPT 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) (not) view the body after death.										22c. DATE SIGNED 9-21-87				
22b. SIGNATURE <u>John Weigel, M.D.</u>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Weigel, M.D.		
22e. ADDRESS Prince Frederick, Maryland 20678										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				
23b. DATE 9-23-87										23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Mem. Gardens	23d. LOCATION CITY OR TOWN Davidsonville	COUNTY AA	STATE MD	
24. FUNERAL DIRECTOR NAME Rausch FH ADDRESS Owings, MD 20736										25a. DATE REC'D. BY REGISTRAR SEP 28 1987	25b. REGISTRAR'S SIGNATURE <u>John Weigel, M.D.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 26213			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		9 27 87			10:42AM		
Roy Lee Morris													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 5 DAY 19 YEAR 20			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD.						
Va.		USA		Calvert Memorial Hospital									
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver Hauling			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN North Beach			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rosedale RT. 20714				
14. FATHER'S NAME William Morris							15. MOTHER'S MAIDEN NAME Edna Morris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk.		16b. SOCIAL SECURITY NO. 111-22-3278		17. INFORMANT Calvert Memorial			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE		ADDRESS Prince Frederick Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		{ (b)											
		{ (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ALCOHOLISM													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (the hospital) attended the deceased from 9/25 1987 to 9/27 1987, that (I) (we) last saw the deceased alive on 9/27 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/27/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Judge		22e. ADDRESS Prince Frederick, MD 20678											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 1 87		23c. NAME OF CEMETERY OR CREMATORIAL Brethren Cem			23d. LOCATION CITY OR TOWN Free Union Va		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Lansch J.H. Owns		ADDRESS Md 20736		25a. DATE REC'D. BY REGISTRAR OCT 01 1987			25b. REGISTRAR'S SIGNATURE Julia Sanderson-Lansch						

105-100-002500

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be

ATTENDED BY A CERTIFIED PHYSICIAN AND COMPLETED, FILLED IN BY THE FUNERAL DIRECTOR. PAGE 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH.  
TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completed, it may be used for any carbon copies. Pages 1 and 2 should be detached for use on the funeral director permit. This certificate is issued by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 / 2627										
REG. NO.																						
1 - STATE REGISTRAR			007			FIRST			MIDDLE			LAST			DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	P
			Maude			G			O'Berry						09/24/87						9:05	M
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS							
Female			White			MONTH DAY YEAR			82			MONTHS DAYS			HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
England			USA			May 29, 1905						Calvert										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Pr. Frederick			Calvert House Nursing Home						Cashier			Banking										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE										
Maryland			Calvert			Solomons			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			General Delivery, 20688										
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST							
			Harry Graham						Annie Summersgill													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)			17. INFORMANT			ADDRESS			12830 Holiday Lane										
No			N/A			220-16-8400			Bob O'Berry, Jr.,			Bowie, Maryland 20716										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)															Cardio pulmonary arrest Atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Chronic obstructive pulmonary disease																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b. DATE SIGNED 09/25/87							
22b. SIGNATURE M. MATHUR			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MATHUR			22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 9-26-1987			23c. NAME OF CEMETERY OR CREMATORIAL Solomons UMC Cemetery			23d. LOCATION CITY OR TOWN Solomons, Calvert, Maryland													
24. FUNERAL DIRECTOR NAME Rt 264, Box 34B, Port Republic, Maryland 20670			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 05 1987			25b. REGISTRAR'S SIGNATURE Linda Pendleton													

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. ~~Page 1 should be retained by the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the cremation or removal.~~

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DHMH . 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 6 2 8 0

REG. NO.

1. DECEASED NAME [TYPE OR PRINT]			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Mary A. Polley						09/09/87				2208 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/17/04			6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.							
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comm. Eng.			12b. KIND OF BUSINESS OR INDUSTRY Communications					
13a. STATE MD		13b. COUNTY Calvert		13c. CITY OR TOWN Ches Beach		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 87 Bayside Rd/20732						
14. FATHER'S NAME FIRST MIDDLE LAST John F. Polley			15. MOTHER'S MAIDEN NAME Mary			16. SOCIAL SECURITY NO. 577-01-3095			17. INFORMANT ADDRESS John E. Polley 400 Army Navy Dr. Arlington, VA 22202					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>congestive heart failure, Diabetic cellulitus advanced age</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from show the deceased and others on 5-10-87, 1987, to 5-10-87, 1987, that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.											22b. SIGNATURE <i>Ronald J. Ross MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 0540 5-10-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ronald J. Ross MD</i>		22e. ADDRESS <i>Prince Frederick MD</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 9-12-87		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spr		COUNTY PG	STATE MD				
24. FUNERAL DIRECTOR NAME RAUSCH FH		ADDRESS OWINGS, MD 20736			25a. DATE REC'D. BY REGISTRAR SEP 14 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Landess</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and submitted to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon Rogers, Box 156, and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 6 2 8				
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Rogers James Whittington						9 10 87						1930 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 20, 1927			6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Retail					
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Pr. Frederick		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6056 Daybreak Dr / 20678					
14. FATHER'S NAME John		15. MOTHER'S M AIDEN NAME Elizabeth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 45-46			17. INFORMANT Annie M. Whittington -Same as #13-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>PNEUMONIA.</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/8, 1987, to 9/10, 1987, that (I) (we) last saw the deceased alive on 9/10, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Death Reg.</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/11/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Judge, M.D.		22e. ADDRESS Prince Frederick, Maryland 20678											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-87		23c. NAME OF CEMETERY OR CREMATORIAL Md Veterans Cem			23d. LOCATION CITY OR TOWN Cheltenham, Pr Georges, Md.			COUNTY STATE			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		P. O. Box 156 ADDRESS Waldorf, Md 20601			25a. DATE REC'D. BY REGISTRAR SEP 15 1987 25b. REGISTRAR'S SIGNATURE <i>John L. Johnson</i>								
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified or one

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8126282			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Amos			E	Young		September 20, 1987						1055 M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		March 25 1913			74 YRS			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Calvert MD.			
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Prince Frederick		Calvert Memorial Hospital					Truck Driver						
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Pr. Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 137		20678			
14. FATHER'S NAME FIRST William		MIDDLE Young		15. MOTHER'S MAIDEN NAME FIRST Nancy		MIDDLE Brooks		LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT Leonard Young 4979 Huntington Rd.		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		217-09-4368											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) OF PANCREAS.								6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/21/87 to 9/20/87, that (I) (we) last saw the deceased alive on 9/20/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Anwar Munshi		DEGREE M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 9/21/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.		22e. ADDRESS Prince Frederick, Maryland 20678											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 24-87		23c. NAME OF CEMETERY OR CREMATORIAL Garddens Dunkirk		23d. LOCATION CITY OR TOWN Calvert		CITY OR TOWN Calvert		COUNTY STATE Md			
24. FUNERAL DIRECTOR NAME Spencer E. Sewell		ADDRESS 1451 Dares Beach Rd. Prince Frederick, Md 20678		25a. DATE REC'D. BY REGISTRAR OCT 02 1987		25b. REGISTRAR'S SIGNATURE Julie S. S. Rodell							
DHMH - 16 60M 7/84 (VRA 15, 4)													

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